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Inventory

A QUARTERLY JOURNAL ON ALCOHOL AND ALCOHOLISM
PUBLISHED BY THE N. C. DEPARTMENT OF MENTAL HEALTH

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STATEMENT ON ALCOHOLISM

"Our lack of knowledge is exceeded by our seriously inadequate efforts to apply what we already know to the detection, prevention, treatment, and rehabilitation of the victims of alcoholism."

BY ROGER EGEBERG, M.D.

I don't intend to launch into a recitation of departmental activities relating to alcoholism, because on the one hand this kind of information can be made available to the committee more succinctly and fully than I might detail it in this statement, and on the other hand because I myself an just beginning to become familiar with our work in this field. But let me say at the outset that I am no stranger to the medical, social, and psychological problem of alcoholism. One cannot spend as many years as I have in the practice of medicine, in the direction of large hospitals, and in the training of doctors without becoming profoundly impressed by this complex, cruel disease.

I suppose, like anyone else, my background predisposes me to a point of view about alcoholism, and that point of view is simply this: The worsening problem of chronic alcoholism in this country reflects the progressive failure of our health care

Dr. Roger Egeberg is assistant secretary for health and scientific affairs of the U. S. Department of Health, Education and Welfare. He made this statement in July of 1969 before the Subcommittee on Alcoholism and Narcotic Addiction of the Committee on Labor and Welfare, United States Senate.

system to meet the demands placed upon it.

Let me be very specific here. I do not mean to suggest that medical science and psychology have learned all there is to know about alcoholism. Far from it. We are still very much in the dark about the effects of alcohol on the body and on the mind. A great deal more research is needed to unravel the biochemical activity triggered by alcohol, and particularly the variability among individuals in their response to alcohol. These and many more fundamental questions must be given greater emphasis, and I intend to press for necessary expansion in these critically important research areas.

But, our lack of knowledge, in my view, is exceeded by our seriously inadequate efforts to apply what we already know to the detection, prevention, treatment, and rehabilitation of the victims of alcoholism. Here is the great and growing tragedy. We could be doing much more to apply what we know and to pave the way for the effective use of new knowledge that will come from research.

I firmly believe that one of our major priorities must be to create a national program that can bring the alcoholic patient into contact with the kind of help he needs—medical help, psychological help, social help, rehabilitation, in short all the arms of support that can check the progress of alcoholism in the individual and in our whole society.

I believe it is my responsibility—I assure you it is my firm intention—to work for the establishment of such a national program. Not a Federal program, but a program involving Federal and State governments, local agencies public and private, the universities, industry—for indeed every institution in our society has a job to do in the battle against alcoholism.

There are, within the Department of Health, Education and Welfare, some serious shortcomings that must be corrected. As of now, for example, we are not making use of a very effective tool that could help build the national program that I believe is needed. The community mental health centers, of which there are now 375 in operation serving a population of 53,000,000 people, have already been identified as foci of a comprehensive Federal-State effort to help the victims of alcoholism. Budgetary restrictions have not permitted us to move as swiftly as we would like to implement our new authority in this area. But within the means available to us, we intend to make the best possible use of the authority to emphasize alcoholism in the programs of these centers.

There is a crying need for employee health programs to help detect and care for alcoholics. I think it is only reasonable for the Federal Government, one of the nation's largest employers, to strengthen its efforts toward the care of chronic alcoholics. The Federal Employees Health Service has recently taken a leadership role in training its personnel so they can offer appropriate assistance to those federal employees who have drinking problems. We ought to be a model for all of industry. I hope so.

A Principal Barrier

In the context in which I view the problem of alcoholism, that is, in the context of health care, I believe that one of the principal barriers that has to be overcome is a shortage of trained, skilled manpower. No matter how productive our research, no matter how successful our efforts to build necessary facilities, if we lack the people to help the alcoholic in his struggle to regain health and stay healthy, we will have promised much and achieved little.

Through the National Center for the Prevention and Control of Alcoholism, the focal point for the depart-

(CONTINUED ON PAGE 31)

Elementary School

Will you please put the Cooleemee Elementary School Library on your mailing list for *Inventory*? Thanks.

Mrs. Marjorie R. Royle
Cooleemee, N. C.

Junior High School

Would you please put our library on your mailing list for *Inventory* and send us as many back copies as you can? Our 9th grade students do units on alcohol, and these magazines can help.

Mrs. Brenda Scoggins
Mooresville Junior High School
Mooresville, N. C.

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Please add our library to your mailing list for *Inventory* so that our students and faculty will have access to current materials in your subject area.

Marcus B. Everitte
Robeson Technical Institute
St. Pauls, N. C.

University

Please place our name on your mailing list to receive *Inventory*. Such materials are placed in the library for the use of our faculty and students.

Mrs. Jo Ann Bell
School of Allied Health Professions
East Carolina University
Greenville, N. C.

Sees Effects on Family

Will you please place me on your mailing list for *Inventory?* As a social worker in a Child Psychiatry Clinic, I have seen the effects of serious drinking problems on family life and I am involved in offering help to parents with alcohol problems.

Mrs. Helena Hershkowitz
Chapel Hill, N. C.

Helpful to Nurse

Would you please start sending me *Inventory?* I am a registered nurse at a state institution and feel that it would be helpful in my work. Thanks.

Miss Rosemary Cattle
Butner, N. C.

Chaplain Likes Articles

Recently I scanned *Inventory* and was quite pleased with the articles. As I am a chaplain in a mental health center and have frequent contacts on the alcoholic unit, I am always in need of good articles to read. Please place me on your mailing list.

Paul Podraza
Vernon, Texas

Benefits Family

Thank you for *Inventory*. My family and I feel that we have benefited personally from its information.

Anonymous
Raleigh, N. C.

Used in Training

The Kentucky Mental Health Manpower Commission is engaged in a long-term research project aimed at training mental health workers in three new roles. One area in which our technicians and aides will be trained is working with alcoholics. We have had opportunity to read *Inventory* and have found it helpful in planning our curriculum for the two-year Associate of Arts degree.

Sam B. Conner
Research Associate
Louisville, Kentucky

ALCOHOLISM

A MERRY-GO-ROUND NAMED

BY REV. JOSEPH L. KELLERMANN
DIRECTOR
CHARLOTTE COUNCIL ON ALCOHOLISM
CHARLOTTE, N. C.

This article, edited from the original booklet published by the Charlotte Council on Alcoholism, Inc., is published in *Inventory* by permission of the author. A version has also been published by the Al-Anon Family Group Headquarters, Inc. Rev. Kellermann is a widely known proponent of the "family approach" to the treatment of alcoholism.

To understand alcoholism, we must look at the alcoholic as if we were sitting in the audience watching a play and observing very carefully the roles of all the actors in it.

PART I

Introduction

A person must have the help of at least one other person to become an alcoholic. He cannot become one by himself. Alcoholism cannot appear in a person apart from others, get worse without the help of others, or continue in isolation from other people. When a person drinks too much and gets drunk, other people react to this kind of drinking and its results by blaming him. The drinker responds to their reaction with denial and drinks again. The downward spiral of this merry-go-round of blame and denial is what we call alcoholism. We can look at alcoholism as a tragic three act play in which there are at least four characters—*The Alcoholic*, *The Enabler*, *The Victim* and *The Provocatice*.

To look at the alcoholic, to read a scientific description of alcoholism, or to listen to the tales of woe and troubles of the family alone is only a small part of the drama. To understand alcoholism, we must look at the illness of the alcoholic as if we were sitting in the audience watching a play and observing very carefully the roles of all the actors. *Denial* is the name of the play because it is the key word in alcoholism. Again and again the actors do what they say they will not or deny what they have done. If we could watch the action on television with the sound off, we could understand much better what is really happening.

The alcoholic is the star of the first act. He does all the acting while the others react to what he does. Usually,

he is a male between the ages of 30 and 55, smart, skillful, and often very successful in some area of work; but his goal may be far above his ability (or his performance far below). We see also that he is a very sensitive, lonely and tense person. He acts in a very independent way in order to deny that he is very dependent. At the same time he denies that he is responsible for the results of his independent action. However, if others did not permit this kind of action, he would not be able to act this way.

The alcoholic has learned that the use of alcohol makes him feel better. To him it is a blessing, not a curse. From his point of view, it is a medicine, not a poison. Alcohol melts his fears, reduces his tension, removes his loneliness and solves all his problems—for the time being. For a few hours it floats his troubles while he rests. For him, at the moment, it is the answer to all his problems.

Act I

"No one ever tells me what to do, I tell them," the alcoholic says as the play opens. And it's true, especially in the family. Talking becomes difficult. Even when the drinking and its results are causing serious problems that everyone can see, the alcoholic will not discuss them. Talking is a one way street. No one, on either side, seems to hear what the others are saying.

Early in the first act the alcoholic needs a drink so he takes one. He drinks more than others, more often than others and, above all, it means far more to him than to others. He consumes his "pain killer" at a rapid pace in large amounts rather than slow and easy. He may drink openly; but, more likely, he will hide the amount he drinks by not drinking when the other actors in the play are around. Hiding the amount he drinks is the beginning of denial and, when

we see him do this, it proves that he knows that he is drinking too much. Drinking too much is not a matter of choice with him but, too often, the first sign of alcoholism. His repeated denial by hiding the bottle and drinking alone tells us: 1) that he cannot stop drinking after one or two drinks; and 2) how important alcohol is to him in making him "feel better."

After a few drinks we see a profound change in the alcoholic. Alcohol gives him a sense of success, well-being and self-sufficiency. It puts him on "top of the world," and he acts as if he were a little god. He is now right and all others are wrong, particularly if anyone objects to his drinking. There is no one thing all alcoholics do but, while intoxicated or drunk, they are not rational or sensible or responsible. They ignore the rules of social conduct and, at times, are criminal in their activity of which driving under the influence is a clear example. If a sober person acted this way, we would say he was insane.

If drinking continues long enough, the alcoholic creates a crisis, gets into trouble, or ends up in a mess. Although there are many paths he may take to this end, the action is always the same. A dependent person acts as if he were completely independent. He drinks to convince himself that this is true, but the results of his drinking

prove the opposite by making him completely dependent upon others. When he ends up in a mess, he waits for something to happen, ignores it, walks away from it, or cries for someone to get him out of it. Alcohol, which first gave him a sense of being successful and completely independent, now has stripped him of his costume of independence and we see him as a helpless, dependent child.

Act II

In act two three other characters act out their roles and the alcoholic receives the benefit of their action. The alcoholic, himself, does little or nothing but wait for, and expect, others to do for him.

The Enabler

The first character to appear is the *Enabler*. He is a guilt laden Mr. Clean whose own anxiety and guilt will not let him endure the condition of his friend, the alcoholic. He sets up a "rescue mission" to save the alcoholic from the crisis or get him out of trouble because he, the Enabler, cannot bear the pressure of the situation. He is meeting his own need rather than the need of the alcoholic. As a rule, the Enabler is a male outside the family but, at times, this role is played by a member of the family or a woman.

Professionally the role of Enabler is played by ministers, doctors, lawyers and social workers who have not had adequate instruction or education on the subject of alcohol and alcoholism. These members of the so-called helping professions act in the same way as friends by denying the alcoholic the right to learn by correcting his own mistakes. This trains him to believe that there will always be a protector who will come to the rescue, despite the fact that each time they do it the Enablers insist they will never rescue him again. They always have, and the alcoholic believes they always will. Rescue operations may become just as compulsive to Enablers as drinking is to the alcoholic.

The Victim

The next character to come on stage is the *Victim* who may be the boss, the employer, the foreman or supervisor, the commanding officer in military life, a business partner or, at times, a key employee. The Victim is the person who is responsible for getting the work done if the alcoholic is absent due to drinking or is half on and half off the job due to a hangover. Usually by the time drinking interferes with a man's job, he has been working for the same company for ten or fifteen years and his boss has become a very real friend. Protection of the man is a perfectly normal thing and there is always the hope that this will be "the last time." Yet, without repeated protection and cover up by the Victim, the alcoholic would have to give up drinking or give up his job. The Victim's role is to enable the alcoholic to continue drinking in an irresponsible way and keep his job at the same time.

The Provocatice

The third character in this act is the key person in the play, the wife or mother of the alcoholic, the woman with whom he lives. Since she is usu-

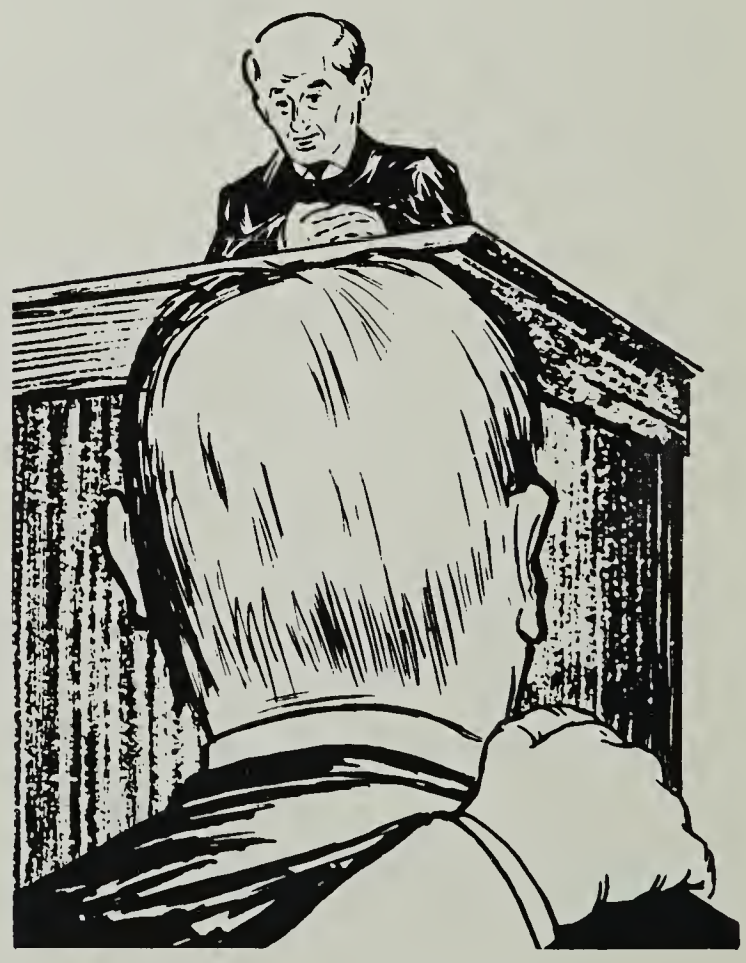
ally the wife, we recognize that she is a veteran at her role because she has played it much longer than other persons in the cast. For lack of a better term, we call her the *Provocatice,* the female provoker. She is hurt, upset and provoked by the repeated drinking episodes of the alcoholic, but she holds the family together despite all the trouble caused by the drinking. In turn she feeds back into her marriage the bitterness, resentment, fear and hurt she feels and becomes a source of provocation. She controls, tries to force things she wants, sacrifices, adjusts, never gives up, never gives in, and never forgets.

Another name for this character might be the *Adjustor,* for she is constantly adjusting to the crises and trouble caused by drinking and its results. The attitude of the alcoholic is one that allows failure on his part, but she must never fail him. He acts in complete independence insisting that he will do as he pleases, while she must do exactly what he tells her to do or not to do. For instance, she must be at home when he arrives, if he arrives. He blames her for everything that goes wrong within the home and marriage, and she does everything possible to try to make her marriage work to prove this is not true.

Or Adjustor

A woman, by nature, is wife and housekeeper and may earn part of the bread. If she lives with a man whose illness is alcoholism, she attempts to be nurse, doctor and counselor. She cannot play these three roles without hurting herself and her husband. She is so upset by what has happened she cannot even talk to him without adding more guilt, bitterness, resentment or hostility to the situation which is almost unbearable as it is. Yet, everything in our present society trains and conditions the wife to play this role. If she does not, she finds herself going against what family and society think the role of wife is. No matter what the alcoholic does, he ends up at home for this is where everyone goes when there is no other place to go.

Act two is now played out in full. The results, effects and problems caused by the alcoholic's drinking have been removed. The entire mess he made is now cleaned up. He has been rescued, put back on the job, and restored as a member of the family. He again wears the costume of a responsible adult. But, since all this was done for him and not by him, his dependency is increased and he is left a child in an adult suit. Even the painful results of drinking were suffered by persons other than the drinker, and thus drinking is permitted to become a very effective problem-solving method for the alcoholic. In act one the alcoholic killed all his pain and woe by getting drunk, and in act two the trouble and painful results of drinking are removed by other people. This teaches him that he may act in an irresponsible way.

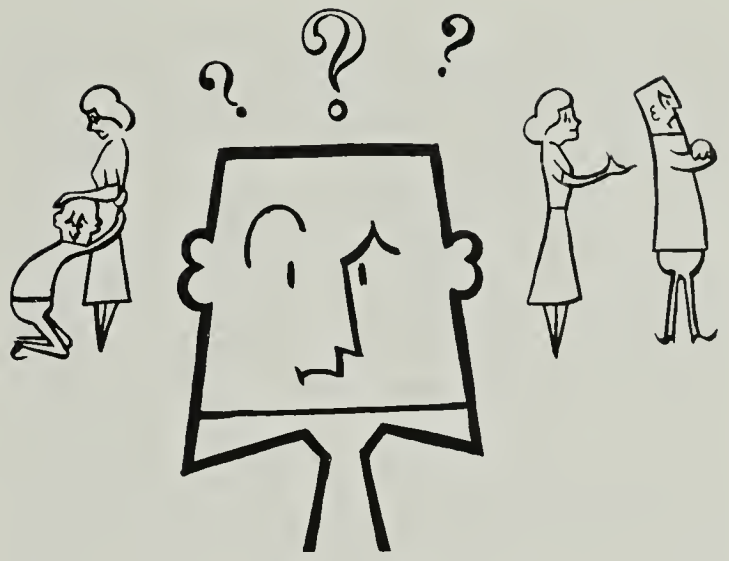


Act III

Act three begins in much the same manner as act one, but something has been added by the action of the first and second acts. The alcoholic's need to deny his dependence is now greater. He expresses it almost at once in a louder and stronger fashion. He denies that he has a drinking problem, that he is an alcoholic, that alcohol is causing him any trouble. He denies that anyone helped him. He denies that he may lose his job and insists that he is the best person at his job. Above all he denies that he has caused his family any trouble. In fact he blames his family, especially his wife, for all the fuss, nagging and problems that exist. He insists that she is crazy, that she needs to see a psychiatrist. In more than half the cases, as the illness and conflict gets worse, the husband begins to accuse his wife of having affairs with other men when he knows this is not true.

There are some alcoholics who achieve the same denial by refusing to discuss anything related to their drinking. The memory of it is too painful. Other alcoholics permit the family to discuss what *they* did wrong and what *they* failed to do whether he was drunk or sober. The wife never forgets what her husband does. The husband may not remember what he did when he was drunk, but he never forgets what his wife tells him he did or failed to do.

The real problem is that the alcoholic knows much of the truth that he so strongly denies. He is aware of his drunkenness. He is aware of his failure. His guilt and remorse become so unbearable that he cannot tolerate criticism or advice from others. Above all, his memory of his utter helplessness and failure at the end of the first act is more than embarrassing; it is excruciatingly painful for a person who thinks and acts as if he were a little god in his own world.



In time the family adjusts to their way of living together. The alcoholic may deny that he will drink again, and others in the play give similar promises—the Enabler, that he will never again come to the rescue; the Victim, that he will not allow another job failure due to drinking; the Provocatice, whether wife or mother, that they cannot continue to live together under these conditions.

What is said is completely different from what everyone has done and will do again. The Enabler, the Victim and the Provocatice have all said these things before but did not act them out. The result of this ambivalence, however, has been to increase the sense of guilt and failure of the alcoholic, challenge his god-like attitude, and add to his heavy burden of tension and loneliness. If this mental pain becomes unbearable—especially by the attitudes and actions of other members of the cast—he will drink again. It is certain the alcoholic in act three will drink again if act two is played out as described, for he has learned by chance or experience that this is the one and only certain means of removing pain, overcoming his guilt and sense of failure, solving all problems and recovering a sense of worth and value. The memory of the immediate comfort and benefits of drinking blot out the knowledge of what will happen if he drinks. Also, there is always in the back of his mind the hope that

this time he can control his drinking and get the great benefits from it that he once did. So, what seems absolutely necessary to the alcoholic occurs. He begins to drink.

When he takes the drink, the play does not come to an end. The curtain closed at the end of act one and act two, but in act three the play suddenly returns to the first act without the curtain closing. It is like watching a three-reel continuous play movie that runs without stopping at any point. If the audience remains seated long enough, all three acts will be played out again in the same way and, at the end of act three, the alcoholic will drink again. As the years go by the actors in the play get older, but there is little change in the words or action of the drama.

Summary

If the first two acts are played as described, then act three will follow in the same way. Without act one, of course, the play about alcoholism would have no beginning and the drama surrounding it would not exist. This leaves act two as the only act in which the tragic drama of alcoholism can be changed—the only act in which recovery can be initiated by the decisions and actions of persons other than the alcoholic. The key to this fact is that in act two the alcoholic accepts what is done for him by others who do these things for him either by choice or because they simply cannot resist doing them. Act two has the real potential to break the downward spiral of alcoholism and its merry-go-round of denial.

PART II

The Beginning of Recovery

It is completely untrue for us to state that an alcoholic cannot be helped until he wants help. However, we can truthfully state that there is almost no chance that the alcoholic will stop drinking as long as other people help him keep on drinking by removing all the painful consequences of drinking.

The actors in the second act kept asking the alcoholic why he did not stop drinking and yet they were the very persons whose actions helped him solve his basic human problems by drinking in this way. If the alcoholic is rescued from every crisis, if the boss allows himself to be victimized again and again, and if the wife reacts as a provoker, there is not one chance in ten that he will recover. The alcoholic is virtually helpless, locked in by his illness. He cannot break the lock by himself, but neither can he keep the merry-go-round going unless others ride it with him and help him keep it going.

A planned recovery from alcoholism must begin with the actors in the second act who hold the key to the lock. If they succeed in breaking the lock, or removing it, the alcoholic is free to come out. These actors cannot demand that the alcoholic give up drinking as a means of solving his problems, but they may be able to help him recover if they learn how to break his dependency on them by refusing to give in to him. To do this they must learn how people affect each other in this illness and to act in an entirely different fashion. The latter is the most difficult part. New roles can be learned by turning to others who understand the play, and putting into practice the insight and knowledge gained from this source.

The people in the second act will find it painful and very difficult to change. It will be much easier and far less painful for them to keep on saying that "the alcoholic cannot be helped" than to go through the pain and agony of learning to play new roles. However, if act two is rewritten and replayed, there is every reason to believe that the alcoholic will recover.

The Enablers and the Victim must seek information, insight and understanding if they plan to change their roles. It is usually necessary for the wife or mother, as Provocatice, to become active in a program of counseling and therapy if she is to make a basic change in her life.

In trying to understand the roles of the three supporting actors in this drama, we must remember that they did not learn to play them overnight. These people play the role that they think is expected of them and have been taught by others to act in this way. They think they are helping the alcoholic and do not know that they are perpetuating the illness and making it almost impossible for the alcoholic to recover.

Understanding the Roles

Friends who are enablers think they must not let the alcoholic suffer the consequences of his drunken behavior when they can be so easily removed by a simple rescue operation. They feel that this is something that simply must be done—like trying to save a drowning man. The rescue mission relieves their fear, guilt and conscience. It also conveys to the alcoholic what the Enabler is really thinking, "You cannot make it without my help." This thought reveals a lack of faith in the alcoholic's ability to take care of himself and is a form of judgment and condemnation.

The most destructive aspect of the role of the Professional Enabler—minister, doctor, lawyer and social worker—is that the family is trained and conditioned to rescue the crises rather than use it to start a recovery program. By the time the alcoholic begins using professional enablers, the family has known for five to ten years that drinking is a serious problem even though this fact was not visible to people outside the family. During this earlier period of alcoholism, before the alcoholic behavior can be seen by outside persons, the family is told by professional persons that the drinker is not an alcoholic and, even if he were, there is nothing they can do unless he actually wants help. Later, when alcoholism reaches the point of outside visibility and the alcoholic turns to professional persons for help, they respond by reducing the crisis.

This is what happens. When alcoholism is in the early stages the family is told that there are no signs of alcoholism. Then, when it becomes visible, the family is taught that the way to deal with it is to remove the symptoms and results rather than come to grips with the problem. They learn this when the professional persons who failed to identify alcoholism in its earlier stages treat the more advanced symptoms by reducing the crisis.

This kind of help and treatment does not lead to recovery. On the contrary, it makes the illness chronic, helps the alcoholic get back on the merry-go-round, and teaches the family again and again that "nothing can be done to cope with alcoholism." When the family is forced to accept the existence of a serious drinking problem, admit that it is alcoholism and turn to professional persons for help for themselves and for the alcoholic, the professional person acts out the role of Enabler instead of leading the family and the alcoholic into a long-range program of recovery.

The Victim does not get on the merry-go-round until the alcoholic has been working for many years. Large industrial firms have discovered that when alcoholism begins to interfere with a man's work he has been employed for ten, fifteen or twenty years in most cases. The foreman protects his alcoholic friend knowing he has a wife and children who will suffer if the man is fired. This is especially true if there is no company policy to help alcoholics recover. Fel-

low workers also protect the alcoholic's job because this man is their friend. Personal interest and friendship cause the Victim to do for the alcoholic things that increase his dependency and add to his need for denial.

The wife, or Provocatice, is the first person who joins the alcoholic on the merry-go-round. If she absorbs injustices, suffers deprivation, endures repeated embarrassments, accepts broken promises, is overthrown or undermined in every effort to cope with the drinking situation, and is beaten by the constant expression of hostility directed toward her, she will automatically feed back into the marriage her own reaction of hostility, bitterness, anxiety and anger. Playing the role of Provocatice in this way makes the wife sick. She is not a sick woman who made her husband become an alcoholic, but a woman who becomes part of an illness by living with it. She is put in a role which forces her to become a female provoker, the Provocatice. She is caught between the advancing illness of alcoholism and the wall of ignorance, shame and embarrassment inflicted upon her by society. This crushes her and she needs information and counseling, not because she caused her husband's illness, but because she is being destroyed by it. This, in turn, hurts the alcoholic and greatly reduces his chance of recovery.

Another reason why the wife needs help in the plan of recovery is that she will discover she is standing alone if she changes her role and begins to act in a new way. Other members of the cast will treat her as an actor who has deserted a play when there is no substitute or stand-in to take her part. This is especially true if the wife separates from her husband, whether by choice or necessity.

Some wives can change their role after having a few talks with a counselor who has basic knowledge of alcoholism or by attending group meetings in a local alcoholism clinic or mental health clinic. Others gain insight and security by taking part in Al-Anon or family group meetings. Having new friends who understand her new role because they have lived through the pain and agony of their own change is very important to the wife at this time. As relatives and old friends begin to tell her how wrong she is in trying to play a new role, the wife needs people who understand the situation and can give moral support in her search for answers to the problems of alcoholism.

The most basic mistake made by women who seek help for their husband's alcoholism is that they want to be told what they can do to stop

the drinking without realizing that it may take months or a year or two for them to learn a new role in the alcoholic marriage. Six months of regular weekly conferences or group meetings is often necessary before a wife begins to change her feelings and learns to act in a new way. If others in the play do not learn new roles, the wife may need to remain in the group for a period of two or three years before her feelings and emotions will permit a change in role.

The wife enters into this activity of seeking help for herself because she needs this help to recover from her own fears, anxieties, resentments and other destructive forces at work in an alcoholic marriage. As she is able to change, this may change the drinking pattern of her husband, and in many cases such a change leads to recovery on the part of the alcoholic. Few husbands can stand a drastic change in their wives without making basic changes in their own lives, but this desirable result cannot be guaranteed. Many wives seek some form of help and then drop out of a program when the problems of an alcoholic marriage are not solved in a short time.

To Help the Children

If there are children in the family with an alcoholic husband, the wife must seek help outside the family or circle of her own friends if she is to avoid injury to the children. Playing the role of Provocatice places the children between a sick father and a sick mother. The wife who seeks and finds help early enough can prevent much of the harm that is being passed on to the children through her reaction to her husband. The wife who plays the role of Provocatice for the sake of the children is hurting them rather than helping them. At first the wife must seek help for herself. If she seeks and finds this help it will protect the children in many ways, and may open the door to her husband's recovery, which otherwise would not occur. The rate of recovery increases greatly when the wife seeks help for herself and continues to use this help while seeking additional help for her husband.

Morally, no one has a right to play God and demand that the alcoholic stop drinking. The reverse is also true. The alcoholic must have a supporting cast in order to act as if he were a little god by telling everyone what to do while doing as he pleases. The wife has every moral right and responsibility to refuse to act as if her husband were God Almighty whose every wish and commandment she must obey. As a rule she cannot tell her husband anything because he refuses to hear it. Her only effective means of telling him what she means is to learn to act in freedom from his attempt to control and dictate what she is to do. Since this control may be exercised in silence and need not be expressed in words, the real message to the wife is what the husband does, not what he says. This is why she, too, must learn to act in a new way so that he will get her message.

Two things prevent most wives from remaining in long-range programs. First, the husband's attitude toward the new role may range from disapproval to direct threats or violence. Second, responsibilities in the home, particularly if there are young children, make it very difficult for the wife to leave the home for group meetings, counseling or therapy during the day. At night few alcoholic husbands will baby-sit or pay for this service while the wife attends meetings of Al-Anon.

If the couple married at an average age—during the prealcoholic stage of his illness—the wife is the first person who joins him on the merry-go-round when alcoholism appears. It is not until many years later that the Enabler and the Victim start their roles. Therefore, if recovery from al-

coholism is to be initiated before the illness becomes crucial or acute, the wife must initiate the recovery program. Since most people today, including the helping professionals, are unwilling to accept alcoholism as an illness until it reaches the addictive stage of chronic alcoholism, the wife will find herself in the position of a pioneer in the search for help.

If her minister condemns drunkenness, she is ashamed to turn to him. If her doctor fails to recognize the existence of alcoholism in the early stages, medical help and counsel for her is cut off. If conditions become unbearable and she consults a lawyer, he may talk in terms of separation or divorce as the only real service he can offer. This increases her sense of failure as a wife or terrifies her with immediate feelings of anxiety and grief, reactions she would have if she took such action. Therefore, most wives stay on the merry-go-round, or get back on soon after trying to get off.

Until there are drastic changes in our cultural and social attitudes toward drinking and alcoholism, the wife or family member who wishes to initiate a process of recovery from alcoholism must understand that it can be a long and difficult undertaking. However, since she cannot make such a moral choice unless she believes it to be right, she must understand the nature of alcoholism to make it.

We cannot expect the wife to do what is beyond her emotional or financial capacity. However if she (or other family member) is willing to enter into a weekly program of education, therapy, Al-Anon or counseling and work at it for a period of at least six months, changes usually occur not only in her life but often in the life and action of the alcoholic. She must also have the courage to stand against her husband's initial opposition and effort to destroy her own program of recovery if he takes this position. By remaining in a program of her own for months or even a year or two, she may be able to solve problems which at first seemed too difficult to try.

There is no easy way to stop the merry-go-round because it is more painful, at that particular time, to stop it than to keep it going. To spell out definite rules that apply to all members of the Cast is impossible. Each case is different, but the framework of the play remains the same. The wife or family member is able to see the merry-go-round of the alcoholic, but often fails to see that she is the one who provides the help that keeps it going. The hardest part of stopping the repeated cycle is overcoming the family member's fear that the alcoholic won't make it without such help, even though it is the kind of help that permits him to continue to use alcohol as the cure-all for his problems of life.

PART III

Initiating Recovery

If a friend is called upon for help, the occasion should be used as an opportunity to lead the alcoholic and the family into a planned program of recovery.

The professional person who has alcoholics or their family members as clients or patients should learn how to cope with alcoholism. Specific literature is available through local, state and national programs on alcoholism. Short, intensive workshops are also available for professional persons who are willing to spend time and effort learning basic knowledge of alcoholism.

If a wife thinks her husband, or vice versa, has a drinking problem or drinks too much too often, she should seek help and counsel immediately for the purpose of evaluating the situation. If a wife knows her husband has

a drinking problem, she should seek information and counsel in order to find and take part in the best programs designed for her and her needs. Regardless of the kind of help the wife chooses, she should not stop after a few conferences or meetings because changes do not occur overnight. Regular attendance should be continued for months or a year or so for many wives state that it takes them this long to secure the real benefit from a program. This may not seem fair to the wife, but in our present society she has one basic choice—to seek help for herself or permit the illness of alcoholism to destroy her, other members of the family, and perhaps her marriage.

Al-Anon is the most widespread group resource for the family today, just as Alcoholics Anonymous is the most readily available help for the alcoholic. Each have several thousand groups throughout the country. In many communities there are also alcoholism information centers, mental health centers and professional people who have learned enough about alcoholism to give good professional counsel to the family. If she makes a real search, the wife can find a source of help for herself—the only effective method if she is to break the merry-go-round of denial during the early period of alcoholism. Once help is found, the family member must continue to use whatever help is available and build her own program of recovery, preferably within an established group. Starting a recovery program may cause greater suffering, conflict and confusion initially, but in the long run it will be far less painful than helping the alcoholic continue to drink by remaining a member of the supporting cast of the play that keeps the mery-go-round turning.

For those who may wish to structure the merry-go-round for the housewife alcoholic, the process is quite simple. The husband plays all three roles in the second act. If he expects his wife to recover, he must change all three roles. To do this he needs more help than the wife of the alcoholic husband. The husband will deny that he needs help but, after all that is to be expected. The name of the play is, "Alcoholism, A Merry-Go-Round Named Denial."

Here are four simple guidelines to aid the family of the alcoholic: 1) Secure additional alcoholism literature for your own study. 2) Seek out all professional alcoholism services in your community. Use whatever is available for the family and know what is available for the alcoholic. 3) Attend Al-Anon regularly in addition to using professional services. If Al-Anon is not available, attend open meetings of Alcoholics Anonymous. 4) Remember that the family may either help keep the illness going or may start the recovery process. The family should work toward recovery by starting and continuing a change in their roles in the drama of alcoholism.

"If we are ever to achieve
the worthy goals of
rehabilitation, treatment, control
and prevention of alcoholism,
then one of the answers, if not 'the'
answer is through education . . ."

ADDRESS

BY GOVERNOR BOB SCOTT

presented before the
GOVERNOR'S
CONFERENCE ON ALCOHOLISM
Raleigh, North Carolina
March 10, 1970

I am pleased to be here with you today for this most important conference on alcoholism.

As all of you know, I'm sure, the problems of alcohol and alcoholism often tend to be obscured and distorted by emotionalism.

It's sort of like politics and religion; sometimes there is more heat than light shed on the subject. And I suppose some of us in politics may tend to confuse the situation at times when we try to adopt a position that satisfies all of the people we serve.

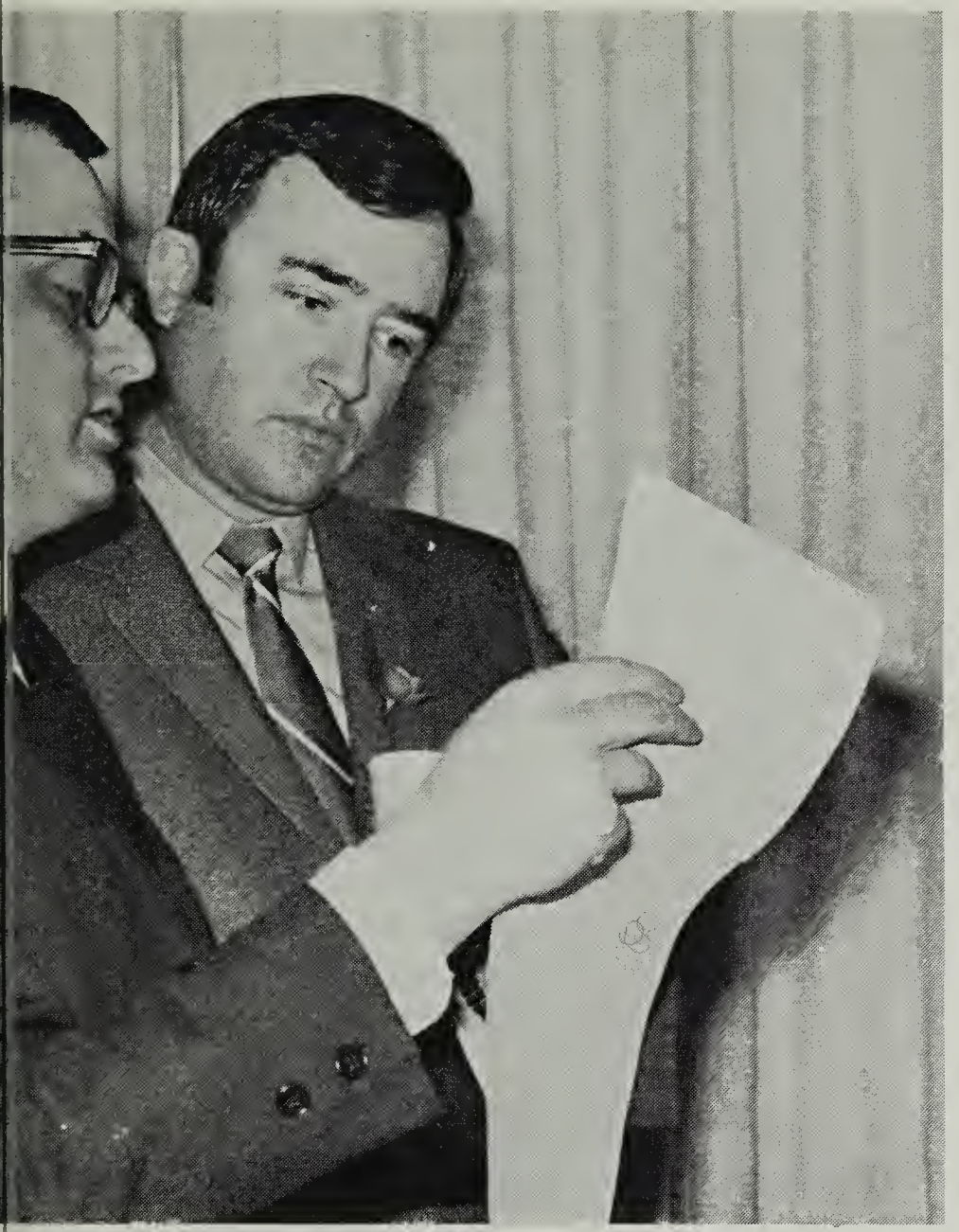
This reminds me of what a congressman from Iowa did one time when he received a letter from one of his constituents, who asked him how he stood on liquor.

This was his reply:

"Dear Friend:

"I had not intended to discuss this controversial subject at this particular time. However, I want you to know that I do not run away from a controversy. On the contrary, I will take a stand on any issue at any time, regardless of how fraught with controversy it may be. You have asked me how I feel about whiskey. Here is how I stand on this question.

"If when you say 'whiskey' you mean the devil's brew, the poison scourge, the bloody monster that defiles innocence, dethrones reason, destroys the home, creates misery and poverty, yea, literally takes the bread from the mouths of little children; if you mean the evil drink that topples Christian men and women from the pinnacles of righteous, gracious living into the bottomless pit of degradation and despair, shame and helplessness and hopelessness—then certainly I



Governor Scott is shown a "print out" from the computer being used in the Regional Alcoholism Systems Project by Fred D. Kennedy, (center), senior analyst of the Research Triangle Institute and member of the R.A.S.P. resource team. Looking on is Harold Holder of the Department of Mental Health, project director. The computer prints out a simulated model of an alcoholism program based on data fed into it.

am against it with all of my power.

"But if, when you say 'whiskey,' you mean the oil of conversation, the philosophic wine, the ale that is consumed when good fellows get together, that puts a song in their hearts and laughter on their lips and the warm glow of contentment in their eyes; if you mean the drink that enables a man to magnify his joy and his happiness and to forget, if only for a little while, life's great tragedies, heartbreaks and sorrows; if you mean that drink, the sale of which pours into our treasuries untold millions of dollars to provide tender care for our little crippled children, our blind, our deaf, our dumb, our aged and infirm, and to build highways, hospitals, and schools—then certainly I am in favor of it.

"This is my stand, and I will not

Editor's Note: *Around 50 persons attended the Governor's Conference on Alcoholism held in Raleigh March 10. Gov. Bob Scott's address before the conference is printed here. Commissioner of Mental Health Dr. Eugene A. Hargrove also spoke. He said that the department's new emphasis on "community programs to solve community problems" will make for greater flexibility and interagency cooperation in combatting alcoholism and other mental health problems.*

A presentation on the "Regional Alcoholism Systems Project" and the resulting South Central Regional Alcoholism Program was made the latter half of the conference. The title of "Consultants to the South Central Regional Alcoholism Program" was conferred on the group which will be asked to reconvene at a later date.

compromise."

If someone should ask me what my stand is on liquor, I suppose my answer would be somewhat similar to what the Iowa congressman wrote.

I'm certainly unalterably opposed to alcoholism and to drunken driving and to all of the miseries caused by drinking, such as loss of job, and income, loss of health, loss of family and friends, and at times, loss of life. And I'm sure you are likewise opposed.

Yet, we all know that there are many people among us who do drink, temperately and moderately, at mealtime and on other occasions without ever causing harm or alarm to society. And we know also that Prohibition taught our ancestors one thing, if nothing else, that people who want to drink bad enough will drink somehow even if we prohibit the manufacture and sale of alcoholic beverages.

What are the answers?

No Easy Answers

To my knowledge, there are no easy answers. Certainly, few, if any, of us would want open, almost uncontrolled sale and use of beverage alcohol, the bar-on-every corner idea. Most people seem to think having outright prohibition would be unrealistic.

That would seem to leave the brown-bagging approach, which we have now, or the idea of having mixed beverage sales at Grade A restaurants. I suppower each of these alternatives has both good and bad points. And, from reading the newspapers last week, it appears fairly certain that this thorny issue will continue for some time to come.

Today, I would like to talk for a few minutes about some concerns I have about the dual problems of alcohol and alcoholism.

As a supplement to what I have to say today, I am providing each of you with a copy of a report on "Alcoholism in North Carolina: Past, Present and Future." This report contains much good information. It tells about what work is going on in North Carolina in the way of alcoholic rehabilitation. I hope you will read it and perhaps give Dr. Hargrove and Dr. Blackley and their associates the benefit of your thinking about their work.

I was particularly impressed in reading this report to see that the educational program of the Department of Mental Health has included seminars, institutes, workshops and summer schools for doctors, ministers, social workers, teachers, nurses, law enforcement officers and others whose work puts them in contact with people who have a drinking problem. This is good. It should certainly continue.

While reading the report, I wondered why it was that the Mental Health Department's magazine, *Inventory,* does not have a greater circulation. Of course, I have never scanned the circulation list of *Inventory* to see who gets it. But I think, just as a beginning, that there should be a copy of each issue in every doctor's office, in every school, college and public library in the State. I think all of the ministers in North Carolina should be on the mailing list, along with our mayors, city councilmen, county commissioners, legislators, business leaders and union officials.

Social workers, and Alcoholics Anonymous groups, and lawyers, and judges, and newsmen, and people in general should also read *Inventory.* The magazine should be available at any ABC store.

The reason I say this is that *Inventory* tells your story. It tells what the Department of Mental Health is doing, and what educators and doctors and judges are thinking and proposing as solutions to the many problems of alcohol and alcoholism. And, perhaps, most important, *Inventory* provides the addresses and telephone

numbers of North Carolina's three alcoholic rehabilitation centers. This is where people in need can get help.

If *Inventory's* circulation is low because of budgetary reasons, then can't you charge a nominal fee for it, especially to out-of-state subscribers?

Now, I would like to mention some other concerns I have about the problems of alcohol and alcoholism.

In mentioning these concerns, I'll ask some questions. Some questions no doubt have already been answered. But I feel that many of my questions have not been answered, but need to be very badly.

As a starter, how many deaths a year are caused by persons drinking moonshine whiskey that contains lead poisons? North Carolina has the dubious distinction of being a leading state in the manufacture and use of moonshine, despite the good work being done by our law enforcement agencies.

Loss of Tax Revenue

Does anyone have any idea of how much tax revenue the State loses each year because some people buy moonshine instead of whiskey from the ABC stores? If that question cannot be answered, then surely it can be determined how many stills were destroyed in 1969, and what the capacity of these stills were, and how much tax revenue would have been lost had these stills not been destroyed.

It is important, of course, to have some idea of how much tax revenue is lost to the State from the operation of liquor stills. But it is far more important to know and understand the problems of alcoholism.

Your presence here today indicates to me that you are vitally concerned about these problems and that you probably have extensive knowledge and experience in dealing with alcoholism. But, is this enough? I don't think so, and the reason I don't think so is because half of our traffic deaths each year involve drunken driving.

I am told that one out of every 50 drivers on the highways is drunk. A sizable proportion of all pedestrians killed on the highways is also drunk. More people arrested by our law enforcement officers and convicted in our courts are guilty either of public drunkenness or drunken driving than any other offense.

Why, if we know so much about alcoholism, are we not solving the one big problem of drunken driving? What are we doing that we should not be doing? What are we not doing that we should be doing?

This is not to take away at all from the work being done by most of our law enforcement and court officials in enforcing the Implied Consent Law and using the breathalyzers. But, I wonder how much coordination there is between the Highway Patrol and the SBI and the other law enforcement agencies with the Department of Mental Health and with the ABC Board, and with employers, and ministers, and doctors, and so on.

You and I know that alcoholism cuts across all social and vocational barriers. There are alcoholics in nearly all walks of life. As time goes on, more and more people seem to be realizing that, yes, alcoholism is a disease, usually a form of mental illness and often a physical illness as well. I think, too, that more and more people are changing their attitudes toward alcohol and alcoholism and alcoholics.

One attitude we need to have is to be really mad at, angry with, the person who combines drinking and driving. We should be just as mad at this person as we are with the person who walks down the street with a loaded gun or the person who resorts to rioting and violence. We need to get rid of the attitude that an alcoholic is a humorous character. We need to do all we can to see that he gets the professional help that you in the Depart-

ment of Mental Health can give him.

I wonder if we could do more in the way of preventing alcoholism, perhaps by beefing-up the curriculum in our junior high grades. Apparently many children at this vulnerable age are first tempted to take a drink. This is where education is so important, where teachers must really be on the ball with statistics, textbooks, films and other visual aids to instruct their pupils. One good publication I've seen along these lines is called "Facts About Alcohol," put out by Science Research Associates of Chicago.

If we are ever to achieve the worthy goals of rehabilitation, treatment, control and prevention of alcoholism, then one of the answers, if not *the* answer, is through education. And, by education, I mean education both in the classroom and out. Many adults need to be educated about alcoholism and the proper use of beverage alcohol just as much as our school children.

And, you, the experts, need continued education, that is, to up-date your knowledge by finding out what laws and programs are in effect in other states and in other countries, by reading professional journals, by communicating with your colleagues, by compiling statistics, by examining past mistakes and past successes to chart your course for the future.

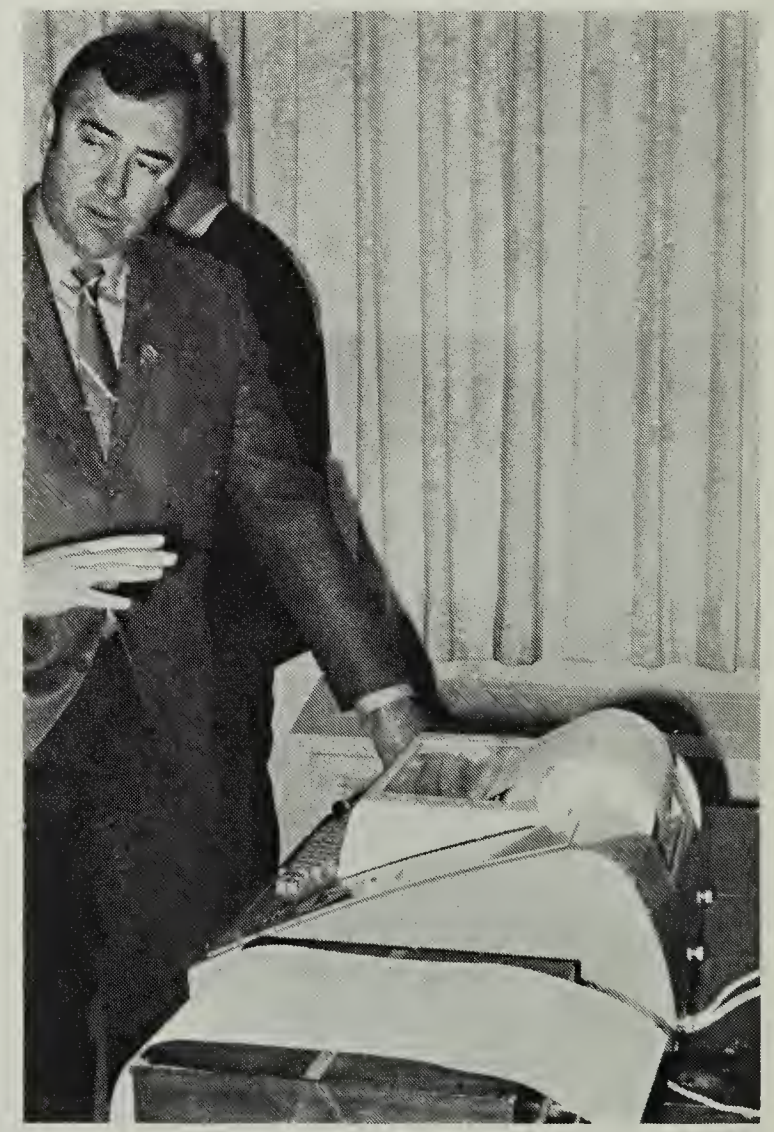
I would urge you, and all citizens, to bear in mind that alcohol is a drug and that it has far more harmful effects on society than heroin and LSD and marijuana, simply because far more people use alcohol to excess than any other drug.

I would also urge you to work closely with such private groups as Alcoholics Anonymous, and A-Anon, and Alateen, and to give your whole hearted support to the establishment of the Center for Alcohol Studies at Chapel Hill. This center, as you may know, is being established as a result of an appropriation from the 1969 General Assembly. Officials at the University in Chapel Hill tell me that they expect to name the director for this center in the very near future. When it is established, this center will be the first of its type in the South.

And, most of all, I would urge you to remember that your work involves, first and foremost, people: the teenagers who take a drink on a dare, the lonely, depressed housewives who drink to compensate for their loneliness, the overworked men who drink to relieve their tensions and anxieties, and the little children who perhaps suffer most of all from excessive drinking.

What is needed, in short, is a complete and enlightened approach to alcohol and alcoholism.

One of my favorite hymns is "Strong Son of God, Immortal Love," which was written by the English poet, Alfred Lord Tennyson. In this hymn is the phrase, "Let knowledge grow from more to more." May your knowledge grow from more to more. Thank you.



SUPPLEMENT TO
Address by Gov. Bob Scott
Governor's Conference on Alcoholism
Raleigh, North Carolina
March 10, 1970

ALCOHOLISM IN NORTH CAROLINA

PAST, PRESENT AND FUTURE

Official alcoholic rehabilitation efforts in North Carolina at the state level date back to 1949. That year the North Carolina General Assembly passed a bill for "establishing further treatment facilities for alcoholics and additional mental health activities for the prevention of alcoholism."
$300,000, responsibility for translating the law into a workable program was placed with the North Carolina Hospitals Board of Control, the governing body of the state mental hospitals, at its own request.

Thus, in North Carolina, alcoholism, traditionally and legally, has been a part of the mental health system.

In the beginning, the Hospitals Board of Control appointed a study committee of its own members headed by the chairman of the alcoholic committee. The recommendations of this committee became the foundation of the North Carolina Alcoholic Rehabilitation Program.

They included: (1) the employment of a full-time executive director as administrative head of the program; (2) the construction of an inpatient treatment center; (3) an arrangement for outpatient services; (4) conducting an educational-informational program; and (5) engaging in research.

In time, all of these recommendations came to pass. An executive director was appointed, the treatment center was opened, and a statewide educational program was launched. A small initial research budget paid for several sociological studies that helped chart the future course of the program. Several community hygiene clinics, in exchange for modest subsidies, made their services available to alcoholics and their families.

The Alcoholic Rehabilitation Center at Butner, which was to serve as the State's only "voluntary" treatment center for 18 years, opened in September of 1950 with a remodeled former Army building as its physical plant. Medical and psychiatric personnel from nearby John Umstead Hospital, a state hospital for treatment of the mentally ill, were assigned to conduct its first treatment program on a part-time basis. The center's fiscal affairs were placed under the supervision of the hospital business staff.

The office of the executive director, which became known as the "educational office," was established in Raleigh. An immediate educational pro-

gram was launched with the result that thousands of North Carolinians from all walks of life have been exposed uninterruptedly to information on alcohol and alcoholism via the mass media, printed material and word of mouth in a continuous statewide educational program.

Inventory, the program's educational periodical, was initiated in 1951. Its mailing list is purposely held to around 23,000 for budgetary reasons. Although mostly circulated in North Carolina, *Inventory* has a limited circulation in all the 50 states and many foreign countries.

The educational office through sponsorship of seminars, institutes, workshops and summer schools, provided special training in alcoholism to hundreds of people—physicians, ministers, social workers, teachers, nurses, law enforcement officers, prison personnel, probation and parole officers, judges and health and welfare workers as well as officials of schools, industry and other organizations.

State grants were initiated early by the Alcoholic Rehabilitation Program as a means of motivating the development of local alcoholism or community programs.

Reorganized in 1959

In 1959, the North Carolina Alcoholic Rehabilitation Program was reorganized by the Hospitals Board of Control. The reorganization provided for a co-directorship shared by an associate director in charge of education and public relations and a medical director in charge of the center and its treatment program. The center was given its own budget along with control of all personnel which included its first full-time medical and social service staff. Patients were admitted directly to the center instead of through the admitting unit of the state hospital.

The next major administrative

Since 1963 the alcoholism

change occurred in 1963, when the General Assembly established the North Carolina Department of Mental Health and the Hospitals Board of Control became the Board of Mental Health.

In this move, the General Assembly consolidated a number of programs—all mental health activities, alcoholism and mental retardation—and placed them in a single administrative unit. The educational office of the North Carolina Alcoholic Rehabilitation Program became the Division of Education of the Department of Mental Health and, of course, legal responsibility for the alcoholism program remained with the Board of Mental Health.

From 1963 to the present time, the alcoholism program has developed and expanded conjointly with our mental health program. The contrast between the past and present programs will provide an impression of the degree of progress that we feel has been made in the past six years.

Prior to the establishment of the Department of Mental Health in 1963, the alcoholism program had a small educational staff to carry out its statewide program and one treatment center for alcoholics to serve the entire state. Now it has the entire resources of the department behind it, and none of the activities or goals of the former program have been eliminated. Indeed, many have been expanded and others have been added.

For example:

The department's Division of Education and its Division of Information and Public Relations are carrying out a statewide educational-informational program.

Instead of one alcoholic rehabilitation center, three are now operating.

program has developed conjointly with our mental health program.

A Division of Alcoholism was established within the Department in 1967. It was given the responsibility of programming the alcoholic rehabilitation centers, dispensing grants-in-aid funds, and working with other state agencies, both official and private.

And finally, in recognition of the seriousness of the alcoholism problem in the State, the position of deputy commissioner on alcoholism was created in 1969 to give alcoholism equal emphasis and visibility with the other program areas—mental health and mental retardation. The deputy commissioner on alcoholism is also director of the Division of Alcoholism.

Before 1963, alcoholic patients were admitted to segregated state psychiatric hospitals—the non-white to Cherry Hospital and the white to Dorothea Dix Hospital. The other two state hospitals did not take alcoholics.

After the Department of Mental Health was established, all four state psychiatric hospitals began admitting alcoholics on an integrated basis. Consequently, the number of alcoholic patients treated at state hospitals has increased dramatically. The number rose from 1,444 admissions in 1962-63 to 4,006 admissions in 1967-68. The budget for the same years was $469,905 and $1,520,871, respectively. The Division of Statistics estimates that there were about 5,000 admissions in 1968-69 at an estimated cost of $1,736,541.

Three of the state psychiatric hospitals have a specialized unit for the treatment of alcoholics, while the fourth treats its alcoholics along with the other patients by the geographic "unit system" method.

The number of A.R.C. beds has increased from 54 in 1963 (at the one center) to 300 in 1969 (at three centers). While the general treatment program has remained essentially the same, there has been an expansion of programs, function and services. For example, greater emphasis is being put on referral for continued treatment, basic and clinical research and follow up of patients in an effort to determine the effectiveness of treatment.

Also, the Alcoholic Rehabilitation Center at Butner, our first, traditionally has accepted only patients who had been sober for at least 72 hours and who came voluntarily. They now accept "committeed" as well as "voluntary" patients. The tradition of accepting only sober patients may begin to change in the future, depending upon the individual programs developed by the regional centers.

Group psychotherapy is the principal method of treatment of the general treatment program of the three centers. Other therapies used are individual psychotherapy and medical treatment, including rest, good nutrition and vitamin supplements.

In addition, the overall rehabilitative program offers vocational counseling, spiritual guidance, recreation, industrial and occupational therapy and the opportunity to participate in the fellowship of Alcoholics Anonymous. Finally, before his release, the patient is referred to an appropriate professional person or agency in his community for continued treatment.

As the centers become firmly established and acquire sufficient staff, they will provide a screening and evaluation service. Each patient, after evaluation by a team consisting of a psychiatrist, social worker, psychologist and vocational counselor, may be entered into the inpatient therapy program at the center, or be referred

to a source of treatment in his own community, or else be referred to a state psychiatric hospital in cases where long-term treatment is indicated.

In addition to the in-service training of its own staff, the centers will help train community alcoholism program workers and expand their cooperation in orientation programs to include teachers, probation and parole officers, police officers, sheriffs, industrial personnel and others. The A.R.C. at Butner has conducted such programs with medical students, public health nurses, ministers, social workers, highway patrolmen, vocational rehabilitation counselors and probation officers.

Regional Programming

We have divided our State into four regions for purposes of mental health programming with a deputy commissioner in charge of program development in each region. The regions each have a psychiatric hospital, a mental retardation center and, with the exception of the South Central Region (which will be explained), an alcoholic rehabilitation center. Further development of alcoholism services in the regions is the responsibility of the deputies and their staffs.

Regions are subdivided into areas on the basis of population, and eventually there will be a comprehensive mental health center for each area. These centers will provide the following services in alcoholism: inpatient, outpatient and emergency treatment, consultation and partial hospitalization.

In addition, as the comprehensive mental health centers are developed, the department will fund a program component which provides alcoholism control services for a mental health program area by agreement with the area mental health authority as prescribed by law.

How effective has this approach been in providing alcoholism services at the local level? Or, more directly, have local areas benefited and to what extent?

In 1962-63, the year just preceding the establishment of the Department of Mental Health, the North Carolina Alcoholic Rehabilitation Program made grants totaling $50,499 to six independent community alcoholism programs for indirect services. Three of these operated on a part time basis. Grants for direct services were made to one mental health clinic, to one family service association, and to the North Carolina Memorial Hospital in Chapel Hill.

More recently, in 1968-69, the Department of Mental Health gave grants in the amount of $209,096.00, out of an appropriation of $299,500 to 28 full-time program components providing direct and indirect alcoholism services in 48 counties.

Another example of increased benefits at the local level is the advent of the South Central Regional Alcoholism Program which represents a total regional effort to develop a comprehensive alcoholism program with emphasis on local administration and participation. Funds for this special program were appropriated by the 1969 General Assembly. Utilizing the Alcoholism Unit at Dorothea Dix Hospital for inpatient treatment as needed, a special program tailormade to meet the needs of alcoholics and their families is currently being implemented in the south central region. The last hour of this conference will deal more in depth with the "Regional Alcoholism Systems Project," which represents a new and innovative approach to deal with the age-old problem of alcoholism, and will include a written report[1] for your information.

[1]Parts of this report and other information will appear in future issues of *Inventory*.

VOL. 19, NO. 2 **INVENTORY** 1969
ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

All cultures can be ranged on a continuum in reference to their attitudes about drinking.

An International Overview

Social and Cultural Factors in Drinking Patterns

(CONTINUED FROM LAST ISSUE)

BY DAVID J. PITTMAN, Ph.D.

Dr. Pittman is a professor of sociology and director of the Social Science Institute at Washington University, St. Louis, Mo. This is the second half of his article, "Social and Cultural Factors in Drinking—An International Overview," which was originally a distinguished lecture of the 1968 John W. Umstead Series of Distinguished Lectures.

Regardless of whether the culture is an abstinent one, a certain amount of drinking occurs, and conversely in the permissive culture a group of abstainers will exist. Thus, although extensiveness of beverage usage correlates with cultural type, it is not a perfect correlation. More specifically, in Hindu culture, an abstinent one, in most of the exterior castes, like "Khatiks," "Bhangis," and "Lodhs," the use of alcohol by both men and women is approved, and the children begin to drink at an early age. Drinking pathologies are found, for example, in Lucknow, India, a wet area, which resemble the Western type of alcoholism. In speaking of inebriate parents who are dipsomaniacs, Srisastua states:

> They (the dipsomaniacs) lose their balance of mind, after a heavy intake and become most irrational in behavior. Invariably in these cases ordinary family obligations are neglected and children particularly are ill treated.

In the Netherlands, an ambivalent culture towards drinking, an excellent study of drinking and smoking habits was conducted on a random sample of the Dutch population in 1958 by the eminent sociologist, Professor Ivan Gadourek. The percentage of abstainers in the adult population is from 15 to 21 per cent; for that 80 per cent of the population which drinks, it does not occur at meals as in Italy. Much the same situation is found in survey results from the State of California in the United States; in the adult sample only 13 per cent were abstainers while the remainder were users.

The extreme of the drinking culture is perhaps found in France where only 4 per cent of the native French population are abstainers. A recent Polish survey on a representative survey of the population 20 years of age and over found 15.7 per cent abstainers, with the percentage 25.1 per cent among women and 7.6 per cent among men. Also, few teetotallers would be found in Italy, Greece, and among the Jews.

Furthermore, the type and amount of beverage alcohol consumed varies from one cultural type to another. In characterization of beverage preferences McCouall has stated:

> Before the war (Second World War) the French drank champagne, Spaniards drank sherry, Portuguese port; Germans drank beer, Italians chianti, Scandinavians *schnapps;* and the Russians drank—and still drink—vodka. In Balkan countries they drank plum brandy calling it *slivovicz* in Yugoslavia, *tswika* in Rumania and other things elsewhere; Greeks drank *retsina,* Turks *arak.* West Indians drank rum. Americans drank cocktails, highballs and iced water.

We doubt whether drinking preferences have changed as radically as McDouall maintains in his article. But changes in preference and consumption patterns have occurred. For example, in 1961 the estimated consumption of whiskey in France was 682,000 gallons which represented a doubling of the 1960 consumption, although much of the whiskey was used for cooking purposes.

In Italy even more dramatic changes in consumption patterns have occurred. In the 20-year period from 1941-1961, there has been a 100 per cent increase in the consumption of wine; beer consumption has increased by 200 per cent and spirits by 400 per cent.

The ingestion of alcoholic beverages in each culture carries with it social psychological functions and meanings. At least two basic ways of classifying the functions of drinking have been suggested. One scheme suggested by social anthropologists and sociologists who adhere to the "Functional School" is to categorize drinking practices as being 1) integrative for the individual and the social system; 2) anxiety-reducing, particularly for the individual; and 3) disintegrative for the social system and the individual.

A scheme more preferred by this writer is the one advanced by Bales who has suggested that alcoholic beverages can serve one or more of the following functions for cultural groups. Those functions are: 1) religious, 2) ceremonial, 3) hedonistic, and 4) utilitarian. Religious functions of alcoholic beverages are numerous. Only mentioned here will be the use of wine to be consecrated for Holy Communion in Roman Catholicism and in some Protestant groups.

Ceremonial usages of alcoholic beverages may be found in connection with many of the major *rites de passage* from birth to death in Western society. Some illustrations can be provided such as the drinking of wine at the Jewish boy's *Bar Mitzvah,* the

carries with it social psychological functions and meanings.

wedding celebration with champagne in the middle classes of America, and the drinking of whiskey by the Irish at wakes.

Hedonistic or pleasurable usages of alcoholic beverages are also well documented. One form is basically convivial in which the individual drinks with another or a group to show his solidarity with friends and kinship groups. Also one may obtain the pleasurable psychological effects of a generally euphoric feeling. This takes linguistic expression in the English language in the phrases—"to get high" or "to have a glow on." In the case of many Western alcoholics, however, what began as a pleasurable activity becomes a burdensome addiction after a period of years.

Utilitarian drinking refers to using drinking to gain some "relief or satisfaction of self-oriented, self-contained needs" or "gain some personal advantage over the other." One notable utilitarian function of alcoholic beverages in Western culture is the use for medicinal purposes. Even during Prohibition, in American society alcohol could be obtained on a physician's prescription. In Irish culture studied by Bales, beverage alcohol was used for a variety of ills such as colds, diarrhea, cholera, and fevers. In his words:

> Its (alcohol) everyday use to begin the day, to get rid of a "hangover," to quiet hunger, to relieve stomach disorder, to get warm, to keep warm, to reward the child, to release sexual and aggressive tensions, to relieve emotional difficulties ranging from minor upsets and disappointments to deep grief, to restore consciousness in case of fainting and shock, to improve the physician's skill, to dispel fatigue and to promote sleep—all of these and more are utilitarian uses . . .

Utilitarian functions of beverage alcohol can be found in most cultures, especially medicinal ones and occasionally against legal prohibitions. In Czechoslovakia, despite legal regulations which prohibit the giving by parents of beverage alcohol to children under 18, parents use alcohol as a medicine against such things as tooth and stomach aches.

In conclusion, it should be sited that the functions performed by alcohol in one culture are related to the whole cultural system and find meaning within that context.

Age and sex status and position in the stratification system are three important variables which all societies use in defining expected behaviors and role performances of their members. They are also related within a society to expected drinking practices and behaviors.

Age grading has been noticed in all human societies. Simply stated, expected behaviors change as the individual moves from childhood to adolescence to maturity to old age. How then is age related to drinking behavior?

A cross-cultural examination shows wide variation in reference to the age at which the individual is allowed access to beverage alcohol. At one extreme are the cases of Italy and France in which the child is at an early age introduced to drinking through his family. The family provides beverage alcohol, especially wine, at meals and for medicinal purposes. Sometimes the child receives too much wine, becomes intoxicated, and requires medical attention. Thus it is no accident that one center for the study of alcoholism in Italy is located within the Gaslini Pediatrics Institute at the University of Genoa. At Genoa Pro-

(CONTINUED ON PAGE 30)

A feature designed to help you keep posted on developments in the field of alcoholism.

1970 N. C. SUMMER SCHOOLS: The traditional statewide N. C. Summer School of A Alcohol Studies has been discontinued in favor of regional summer schools. Two regional summer schools will be conducted in 1970. They are: the Eastern Regional N. C. Summer School of Alcohol Studies, East Carolina University, Greenville, August 9-14; and the Western Regional N. C. Summer School of Alcohol Studies, Blue Ridge Assembly, Black Mountain, July 19-23. It is expected that there will be four regional schools by 1971 to correspond with the four regions of the Department of Mental Health. The summer school course at East Carolina University designed primarily for teachers and prospective teachers will be conducted June 8-19.

1970 RUTGERS SUMMER SCHOOL: June 28, 1970 through July 17, 1970 are the dates for the 1970 Rutgers Summer School of Alcohol Studies to be held at Rutgers—The State University, New Brunswick, New Jersey. Cost of tuition, room and board is $350.00. Announced changes in the program for the 1970 sessions include: 1) A new course designed primarily for Police Academy instructors, but open to other law enforcement personnel, will replace the "Problems of Drinking and Driving" course. 2) A new course entitled "The Clergyman, the Community, and Alcohol Problems" for clergymen in parish, seminary and official positions will be conducted in addition to the "Pastoral Counseling" course. 3) The course "Programs for the Homeless Alcoholic" will be offered in two sections rather than one as in the past. 4) Instead of a two-week physicians institute running concurrently with the first two weeks of the regular course program, the course, "Medical Aspects of Alcoholism," will be offered as a part of the regular three-week program. 5) The usual two lectures each day will be shortened and each will be followed by small, interdisciplinary group sessions.

SPECIAL AWARD: Joe K. Byrd, chairman of the N. C. Board of Mental Health presented a "Certificate of Appreciation" to former board member, R. V. "Bun" Liles at the Gov.'s Conference on Alcoholism March 10. It read: "In recognition of his contribution to the betterment of the State's mental health program through his many years of leadership, devoted service, and outstanding performance as a board member, particularly in the area of alcoholism.

Mrs. Liles and "Bun" Liles

Highlights of the Dedication of

THE WALTER B. JONES ALCOHOLIC REHABILITATION CENTER

Gov. Bob Scott delivered the dedicatory address.

State Senator Julian R. Allsbrook paid tribute to Congressman Walter B. Jones for whom the ARC is named.

GREENVILLE, N. C.
March 13, 1970

Gov. Scott, Congressman Jones and Don Dancy, program director of the Walter B. Jones ARC.

A portrait of Mr. Jones that will hang in the center was unveiled. Congressman and Mrs. Jones stand by the portrait.

SOCIAL–CULTURAL FACTORS

CONTINUED FROM PAGE 27

fessor Dalla Volta has concentrated on the study of child "alcoholism" and its relation to adult alcoholism as well as an examination of the geographic areas where child alcoholism is high. In France educational campaigns under the High Committee of Study and Information on Alcoholism have urged parents not to give wine to the children. The same position has been taken by the Health Ministries in Czechoslovakia, Poland, Hungary, and Yugoslavia for example. Thus in one group of countries children are introduced to beverage alcohol in their homes by their parents at an early age. However, as the cases of France and Czechoslovakia indicate, this practice does not immunize the child against alcoholism as some American observers have naively assumed.

At the other extreme of the continuum is American society in which almost all states prohibit complete access to the purchase and consumption of all types of alcoholic beverages until the legal age of 21. Participation in the drinking subculture occurs before this—in adolescence between ages 16-18. Maddox, from his analysis of studies in America concerned with adolescent drinking, indicates that the drinking practices of youth are highly predictable from the drinking patterns of their parents and that first drinking experiences tend to occur in the home under parental supervision.

Social ambivalence, of course, is indicated in the contradiction between the legal age of 21, when drinking is allowed without restriction, and the earlier introduction into drinking by parents and friends. In late adolescense and early youth (ages 18-21) drinking behavior and expectancies are poorly defined and social control mechanisms are circumvented by the youth. Thus, the stage is set for the development of alcoholic pathologies.

One of the important variables governing drinking is that of sex status. Unfortunately, drinking practices by sex have hardly been studied. Despite this, most surveys do contain some information on drinking status and frequency.

For example, the Dutch sample survey previously cited indicates that sex is among the major causes of variation in drinking habits. In comparison to men, women drink more at home, excessive and habitual drinking is infrequent, and craving for alcohol is rare. In the Polish survey by Swiecicki, the men drank 5.6 times as much intoxicating beverages as women did in the rural area, while in the urban area the men drank four times as much as the women.

An examination of the problems with beverage alcohol which occur in different cultures underlines the fact that we are dealing with many conditions which fall under the general rubric of alcoholism.

We have only time to emphasize the classical work by the late Professor Jellinek in which he differentiates the species of alcoholism into five major types—namely, Alpha, Beta, Gamma, Delta, and Epsilon. Variation is found in type and frequency of the alcoholism as the cultural context changes. Thus, the guiding principle in our discussions should be an awareness that our own cultural backgrounds and experience will govern our conceptions of alcoholism and the therapies we apply to it.

Sociological research into drinking practices and their relationship to the larger sociocultural organization has just begun. On an applied level, a knowledge of the meaning and functions which groups attribute to drinking is essential if social policy is to be formulated and programs to combat drinking pathologies are to be instituted.

STATEMENT ON ALCOHOLISM

(CONTINUED FROM PAGE 3)

ment's efforts in this field, we are supporting a wide range of activities aimed at developing the manpower needed for a national attack on alcoholism. Physicians and paramedical personnel, social workers, clergymen, hospital administrators, judges, and city officials are among those who are not receiving training with the support of the national center.

I don't want to dwell on the work of the center other than to say that its approach toward alcoholism is one that I find very logical and appropriate. Since its creation less than three years ago, the center has devoted much effort to the strengthening of community resources for the care and treatment of alcoholics. Because alcoholism is a complex disorder, it would be entirely wrong to develop a totally new network of specialized programs and services to deal with alcoholism. Instead, the strategy of the center has been one of securing appropriate attention to this medical and social program from a wide range of care giving and educational agencies.

But the center, indeed the Federal Government, can provide only leadership and support. We cannot do all that has to be done to bring alcoholism under control. I intend to give the highest possible priority to work in the field of alcoholism and to see that this serious health problem receives the fullest measure of attention in the planning and programing decisions of the department. And I would hope that others, including this committee, will continue to lend their valued support to our efforts. Frankly, we need all the help we can get, for the gap between what can be done and what is being done about alcoholism is terribly wide.

I would hope to encourage the States to make use of funds available to them under the Comprehensive Health Planning and Services Program. I would hope to encourage industry and labor to expand their efforts to find and help the alcoholic and his family. I would hope to encourage a redoubling of research and training to provide both better knowledge and the manpower to use that knowledge.

There can be no doubt that the problem of alcoholism has received far less attention than it demands. We are only beginning to see an awakening to the seriousness of this problem and to the potential for dealing with it. The National Advisory Committee on Alcoholism has made a significant contribution toward generating greater attention to this field and I hope to stimulate this advisory committee to carry forward the important work it has done over the past three years.

Congressional Support

I think, too, that the Congress itself has been highly effective in bringing needed attention to the problem of alcoholism. This committee, the Subcommittee on Alcoholism and Narcotic Addiction of the Committee on Labor and Welfare of the United States Senate, has played a vitally important role not only in guiding the efforts of the Federal Government but also in focusing national concern on the subject of alcoholism. May I say that I am grateful for this Congressional interest and support, for without it a difficult task would be doubly hard.

In conclusion may I say this: There are somewhere between four and a half and six million alcoholics in this country, and most of them are not getting the care they need. If they were, experience shows that a great many of them could be restored to healthy, useful, and productive lives. The challenge we face as a Nation is to help these people. For my part and to the best of my ability, that is what I intend to do.

DIRECTORY OF OUTPATIENT FACILITIES BY COUNTY —for ALCOHOLICS and/or THEIR FAMILIES

Key to Facilities

+ Community Alcoholism Program
(supported jointly by the community and the N. C. Department of Mental Health)

*** Community Alcoholism Program**
(supported largely by funds from local boards of alcoholic beverage control)

‡ Joint Mental Health and Alcoholism Services
(supported by the community and the N. C. Department of Mental Health)

† Mental Health Facility
(supported by the community and the N. C. Department of Mental Health whose services are available to alcoholics and their families)

Competent Help Is Available At The Local Level

ALAMANCE—

\+ *Alamance County Council on Alcoholism*, Room 802, N. C. National Bank Bldg., Burlington 27215; Tel: 919-226-4403.

† *Alamance County Mental Health Clinic*, 221 Graham-Hopedale Rd., Burlington 27215; Tel: 919-227-6271.

ALLEGHANY (See Watauga)

ANSON—

† *Anson County Health Department*, Wadesboro 28170; Tel: 704-694-2516.

* *Education Division, Board of Alcohol Control*, 127 Wade St., P. O. Box 39, Wadesboro 28170; Tel: 704-694-2711.

AVERY (See Watauga)

BEAUFORT (Hyde, Martin, Tyrrell, Washington)—

† *Tideland Mental Health Center*, 418 West Second St., Washington 27889; Tel: 919-946-4640.

BERTIE (Gates, Hertford, Northampton)—

† *Roanoke-Chowan Mental Health Service*, 316 South Academy St., Ahoskie 27910; Tel: 919-332-4137; and 108 Dundee St., P. O. Box 143, Windsor 27983.

BLADEN (See Robeson)

BUNCOMBE—

† *Alcohol Information Center*, Parkway Offices, Asheville 28802; Tel: 704-252-8748.

† *Mental Health Center of Buncombe County*, 415 City Hall, Asheville 28801; Tel: 704-254-2311.

BURKE—

* *Burke County Council on Alcoholism*, 211 N. Sterling St., Morganton 28655; Tel: 704-443-1221.

CAMDEN (See Pasquotank)

CARTERET (See Craven)

CABARRUS—

† *Cabarrus Mental Health Complex*, 102 Chruch St., N.E., Concord 28025; Tel: 704-786-1181.

CATAWBA—

* *Catawba County Council on Alcoholism*, 420 Seventh Ave., S.W., Hickory 28601; Tel: 704-328-3564.

CHOWAN (See Pasquotank)

CLEVELAND—

† *Cleveland County Mental Health Clinic*, 101 Brookhill Rd., Shelby 28150; Tel: 704-482-3801.

CRAVEN (Carteret, Jones, Pamlico)—

‡ *The Neuse Clinic*, 2000 Neuse Blvd.:

\+ *Alcohol Information Division*, P.O. Box 2535, New Bern 28560; Tel: 919-638-4171.

\+ *Alcohol Information Division*, 506 Broad St., P. O. Box 82, Beaufort 28516; Tel: 919-728-4033.

COLUMBUS (See Robeson)

CUMBERLAND—

† *Cumberland County Mental Health Center*, Cape Fear Valley Hospital, Fayetteville 28302; Tel: 919-484-8123.

CURRITUCK (See Pasquotank)

DARE (See Pasquotank)

DUPLIN (See Onslow)

DURHAM—

† *Department of Psychiatry*, Duke University Medical Center, Durham 27706; Tel: 919-684-8111, Ext. 3416.

* *Durham Council on Alcoholism*, 602 Snow Bldg., Durham 27702; Tel: 919-682-5227.

EDGECOMBE (NASH)—

† *Edgecombe-Nash Mental Health Center*, 359 Falls Rd., P. O. Box 2312, Rocky Mount 27801; Tel: 919-442-8021.

FORSYTH—

† *Department of Psychiatry*, Bowman Gray School of Medicine, N. C. Baptist Hospital, Winston-Salem 27103; Tel: 919-725-7261.

† *Forsyth County Department of Mental Health:*

† *Alcoholism Program of Forsyth County*, 802 O'Hanlon Bldg., 105 W. 4th St., Winston-Salem 27101; Tel: 919-725-5359.

† *Forsyth County Mental Health Unit*, 1020 E. 7th St., Winston-Salem 27101; Tel: 919-722-0364.

FRANKLIN—

† *Franklin County Family Counseling and Education Center*, Rt. 1, Box 1X West, River Rd., Louisburg 27549; Tel: 919-496-4111.

† *Gaston County Mental Health Center:*

† *Center for Alcohol Related Problems*, 302 S. York St., Gastonia 28052; Tel: 704-864-9771.

GATES (See Bertie)

GUILFORD—

* *Alcohol Education Center,* P. O. Box 348, Jamestown 27282; Tel: 919-454-2794.

Family Service Agency, 1301 N. Elm St., Greensboro 27401; Tel: 919-273-0523.

Family Service Agency of High Point, 113 Gatewood Ave., High Point 27260; Tel: 919-883-1709 or 919-833-2119.

† *Greensboro Council on Alcoholism,* 216 W. Market St., 206 Irvin Arcade, Greensboro 27401; Tel: 919-275-6471.

† *Guilford County Mental Health Center,* 300 E. Northwood St., Greensboro 27401; Tel: 919-273-8281.

† *Guilford County Mental Health Center,* 942 Montlieu Ave., High Point 27262; Tel: 919-888-9929.

HALIFAX—

† *Halifax County Mental Health Center,* 701 Jackson St., P. O. Box 577, Roanoke Rapids 27870; Tel: 919-537-6174.

HARNETT (See Lee)

HENDERSON—

* *Alcohol Information Center,* 2nd Floor, City Hall, P. O. Box 472, Hendersonville 28739; Tel: 704-692-8118.

† *Henderson County Mental Health Clinic,* 820 Fleming St., Hendersonville 28739; Tel: 704-692-2138.

HERTFORD (See Bertie)

HOKE (See Moore)

HYDE (See Beaufort)

IREDELL—

† *Iredell County Mental Health Clinic,* 221 South Center St., Statesville 28677; Tel: 704-872-7901.

JONES (See Craven)

LEE (Harnett)—

† *Lee-Harnett Mental Health Clinic:*

\+ *Division on Alcoholism,* 106 W. Main St., P. O. Box 2428, Sanford 27330; Tel: 919-755-4129 or 919-755-4130.

LENOIR—

† *Lenoir County Mental Health Clinic,* 111 South McLewean St., Kinston 28501; Tel: 919-527-1196.

MARTIN (See Beaufort)

MECKLENBURG—

* *Charlotte Council on Alcoholism,* 1125 E. Morehead St., Charlotte 28204; Tel: 704-375-5521.

† *Mecklenburg County Mental Health Center,* 316 E. Morehead St., Charlotte 28202; Tel: 704-334-2834.

* *The Randolph Clinic, Inc.,* 1804 East Fourth St., Charlotte 28204; Tel: 704-333-9026.

MONTGOMERY (See Moore)

MOORE—

* *Moore County Alcoholism Program,* P. O. Box 1098, Southern Pines 28387; Tel: 919-692-6631.

† Sandhills Mental Health Center (Hoke, Montgomery, Moore, Richmond):

† *Alcoholism Services,* Medical Center Bldg., Pinehurst 28374; Tel: 919-295-6851.

NASH (See Edgecombe)

NEW HANOVER—

* *New Hanover County Council on Alcoholism,* 211 N. Second St., Wilmington 28401; Tel: 919-763-7732.

† *Southeastern Mental Health Center,* 920 S. 17th St., Wilmington 28401; Tel: 919-763-7342.

NORTHAMPTON (See Bertie)

ONSLOW (Duplin)—

† *Onslow-Duplin Mental Health Clinic,* 225 Wilmington Hwy., P. O. Box 547, Jacksonville 28540; Tel: 919-347-5118.

ORANGE—

† *Alcoholism Clinic of the Psychiatric Outpatient Service,* N. C. Memorial Hospital, Chapel Hill 27514; Tel: 919-942-4131, Ext. 336.

* *Orange County Council on Alcoholism,* Box 277, Carrboro 27510; Tel: 919-942-1089 or (if no answer) 919-942-1930.

PAMLICO (See Craven)

PASQUOTANK (Camden, Chowan, Dare, Perquimans, Currituck)—

‡ *Albemarle Area Mental Health and Alcoholism Service,* P. O. Box 645, Medical Bldg., Elizabeth City 27909; Tel: 919-335-1663.

PERQUIMANS (See Pasquotank)

PITT—

† *Coastal Plain Mental Health Center,* 1827 W. Sixth St., Greenville 27834; Tel: 919-752-7151.

\+ *Pitt County Alcohol Information and Service Center,* 907 Forbes St., P. O. Box 2371, Greenville 27834; Tel: 919-758-3159.

RICHMOND (See Moore)

ROBESON (Bladen, Columbus, Scotland)—

† *Southeastern Regional Mental Health Center,* Medical Arts Bldg., Lumberton 28358; Tel: 919-739-7601.

ROCKINGHAM—

† *Rockingham County Mental Health Center,* P. O. Box 55, Wentworth 27375; Tel: 919-349-7021.

ROWAN—

* *Educational Division, Rowan County ABC Board,* P. O. Box 114, Salisbury 28144; Tel: 704-633-1641.

† *Rowan County Mental Health Clinic,* Community Bldg., Main and Council Sts., Salisbury 28144; Tel: 704-633-3616.

SCOTLAND (See Robeson)

TYRRELL (See Beaufort)

VANCE—

† *Vance County Mental Health Clinic,* County Home Rd., Henderson 27536; Tel: 919-492-1176 or 919-438-4813.

* *Vance County Program on Alcoholism,* 158 Bypass W., P. O. Box 1174, Henderson 27536; Tel: 919-438-3274 or 919-483-4702.

WAKE—

† *Mental Health Center of Wake County,* Wake Memorial Hospital, Raleigh 27610; Tel: 919-834-6484.

* *Wake County Health Department,* 3010 New Bern Ave., Raleigh 27610; Tel: 919-833-1655.

WASHINGTON (See Beaufort)

WATAUGA (Alleghany, Avery, Wilkes)—

† New River Mental Health Center:

\+ *Division on Alcoholism,* 210 W. King St., Boone 28607; Tel: 704-264-8759.

\+ *Division on Alcoholism,* 101-A W. Main St., Wilkesboro 28697; Tel: 919-838-3551.

WILSON—

* *Wilson County Council on Alcoholism,* Room 308, 116 S Goldsboro St., Wilson 27893; Tel: 919-237-0585.

† *Wilson County Mental Health Clinic,* Encas Rural Station, Wilson 27893; Tel: 919-237-2239.

WILKES (See Watauga)

EDUCATION AND INFORMATION SERVICES

INVENTORY—quarterly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from the Film Library, N. C. State Board of Health, Raleigh, N. C. Please request films as far in advance as possible and state second and third choices.

The New Cornerstones—Family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

Library Books—Books on alcoholism are available from the North Carolina State Library through local libraries to residents of North Carolina. To obtain any of the books listed in the March-April, 1964 issue of **Inventory**, go to your community library and make the request.

Staff Speakers—members of the Raleigh and A.R.C. staffs are available for speeches before civic and professional groups.

Teacher's Guide—kit containing reference material and pamphlets on alcoholism and mental health. Available to teachers from the Education Division, N. C. Department of Mental Health, Raleigh.

Consultant Service—for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

Education Division, N. C. Department of Mental Health
P. O. Box 26327
Raleigh, N. C. 27611

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